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Venereal Disease Control—A Continuing Challenge

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Are we ready to accept the statement that syphilis is a vanishing disease, and gonorrhea and the other venereal diseases are no longer of public health significance? Although some progress has been made toward this Utopian ideal, complacency in control efforts certainly is not justified.

The extent to which progress has been made was pointed out by Dr. Theodore J. Bauer^{1*} in a recently published article. In the United States syphilis morbidity dropped to a new low of 214,000 cases in the Fiscal Year 1951, a reduction of approximately 66 percent since 1943. In 1951 there were 280,000 cases of gonorrhea reported, a 40 percent decrease since 1943. Syphilis mortality rates and admissions to mental hospitals for psychoses due to syphilis both declined by 50 percent between 1939 and 1949. However, the fact that half a million cases of venereal disease are reported each year should be ample cause for continuance of adequate control measures.

Dr. W. H. Aufranc² reports that in this Country there are still 3,000,000 people with serologic evidence of syphilis infection; 14,000 syphilitic infants were born in 1951; 13,000 persons died of syphilis; and 6,000 persons were sent to mental hospitals because of syphilis. Certainly syphilis is not yet a vanishing disease.

California Figures

California figures parallel those of the Nation with 8,951 cases of syphilis reported for the calendar year 1951, a decrease of 70 percent since 1943. Gonorrhea, with 17,131 cases reported in 1951, showed an increase of 16 percent over 1943 when 14,632 cases were reported. Since 1943, syphilis mortality in California has declined by 60 percent and admissions to mental hos-

pitals have decreased by 50 percent. Numerically, in 1951 there were 700 deaths due to the venereal diseases, over 400 admissions to mental hospitals resulting from central nervous system syphilis, and 342 cases of congenital syphilis reported.

Factors Influencing Decline

What are some of the factors influencing favorably the long-term trend in the decline of syphilis? Antibiotic therapy has made a contribution, but not dramatically nor alone, as pointed out by Dr. Joseph E. Moore³ in an evaluation of the syphilis control problem. The decrease in syphilis incidence in Europe and the United States began almost a century ago and has continued downward since then, except during periods of war and civil unrest. Facts other than effective therapy have been responsible for this progress. The fact that public health measures for venereal disease control are of recent development, as well as the fact that the character of syphilis has changed from a virulent acute type of infection to one of great chronicity, suggests that by a process of gradual adaptation the virulence of the syphilis organism has decreased, while individual resistance to the disease has increased. Other important factors in the decreasing incidence of syphilis are attributed to the progressive improvement in socio-economic conditions and the application of modern public health control measures.

The modern public health program in venereal disease control includes the finding and treating of infected people, as well as making information regarding the venereal diseases available to the public. These measures have been effective in reducing infant and adult morbidity, mortality, and admissions to mental hos-

* See references at the end of this article.

pitals to the extent stated earlier. Is it wise, now, to curtail these efforts?

California Control Efforts

Public health efforts in California are reflected in epidemiologic reports which show that an average of 60,000 reports of contacts and suspects of venereal disease have been processed through the State Department of Public Health each year for the past five years, a total of 300,000 individuals in need of medical examination because of exposure to infected individuals or because of a positive routine laboratory test. In addition, approximately 1,500,000 individuals in California are screened annually for syphilis by means of routine laboratory tests, and in each of the last five years the State has distributed enough penicillin to treat an average of 40,000 cases of syphilis and gonorrhea annually. Certainly these are facts that cannot be ignored.

In California, local health departments have curtailed their venereal disease control programs in varying degrees. Clinic hours, medical and nursing staffs, and even epidemiological activities have been reduced, not because the number of patients appearing at clinics has decreased materially, but because of the decrease in the number of patient-visits required to complete treatment. Patients can now be treated in a period ranging from 1 to 15 days, with 95 percent completing treatment in the required time. Before the advent of penicillin, treatment of syphilis ranged from 1½ to 3 years, with only 25 percent completing treatment. Caseholding under the long-term treatment routine was a major problem, whereas today it is a minor one. Undue the long-term treatment, patient-visits were cumulative, therefore it was necessary to continuously increase the staff. Today this is not true, and adjustments have logically been made.

In numbers of patients, the fires still burn almost as brightly as ever, and staff cannot be reduced beyond a reasonable point if we are to continue an adequate control program. The accelerated decline in postwar venereal disease incidence stopped in 1950, when the rate of decrease slowed markedly to the present incidence approximating that of the prewar days. Therefore, too much optimism is not yet warranted.

Eradication Not Possible

Doctor Bauer¹ points out, and also Doctor Moore,³ that complete control and eradication of the venereal diseases are not possible, short of world-wide extinction of the disease organisms. In this respect Doctor Bauer reminds us that the four basic procedures in communicable disease control are:

1. Immunization
2. Isolation of the host

3. Elimination of the intermediate host
4. Destruction of the organism.

Science has not yet provided us with any agent with which to immunize the population against the venereal diseases. For very good and practical reasons it is not possible to physically isolate all the diseased persons and their contacts. In the spread of venereal disease, there is no intermediate host. The only procedure in the control of communicable disease which lends itself to the control of venereal diseases is the destruction of the organism; and this depends upon the finding and bringing to treatment of those who are infected.

At this point we come to the problems of infectiousness, destruction of the causative organism in syphilis, and finding those who are infected.

It is generally accepted that the untreated syphilis patient can potentially spread his infection to others any time during the first four-year period of the disease, so-called early latent syphilis, but with diminishing possibility after the first year of infection. It is generally assumed that in latent syphilis, the period between the so-called early phase and the development of late lesions or symptoms, the patient is rarely, if ever, dangerous to others. However, even after 30 years of infection it is possible to isolate syphilis organisms from individuals with late lesions due to syphilis. Dr. Chester N. Frazier,⁴ et al., have shown that spirochetes occur intermittently in infected rabbits for as long as four years. Our epidemiological experience⁵ over many years raises a grave question regarding the noninfectiousness of latent syphilis. On the average, 100 cases of newly reported infectious syphilis will name 200 contacts. When these contacts are examined about 20 cases of syphilis in other stages are found in the same examined group of contacts, or a total of 50 cases, and in some instances 100 cases of syphilis in all stages are found in the contacts reported by 100 infectious cases. It is possible that some of these so-called noninfectious cases were sources of new cases.

Some health departments are now assuming that with so little infectious syphilis coming to light, they need have no worries about latent and late syphilis. This is an erroneous assumption in view of the possible infectious nature of untreated latent and late syphilis. And what of the 1,600 cases of syphilis now in mental institutions?

Casefinding Still a Problem

The problem of finding previously unknown cases is as great now as ever before. The wide use of the antibiotics for various ills is rendering recently infected persons asymptomatic in the early stages of syphilis. This results in fewer patients coming voluntarily to medical centers for examinations because of symptoms. We believe this is confirmed by the reduction

of medical reports on early lesion syphilis, while reports on early syphilis without lesions have not decreased to the same extent.

What casefinding methods should health departments consider and adopt? The selection would depend upon the objectives of their program or project.

Mass community blood testing surveys are expensive in terms of their syphilis yield, but have been utilized as a public education method. If the survey is directed to specific groups known to have a high venereal disease rate the results would probably compensate for the expenditures involved. Our recent study on congenital syphilis⁶ showed that 34 percent of all such cases reported in California occurred in the Negro group and 41 percent in the Spanish-American group. These two minority racial groups, which represent 12 percent of the State's population, provided 75 percent of the total cases of congenital syphilis reported. Seventy-four percent of the total cases reported were county hospital deliveries, indicating the economic status of the parents.

Another casefinding method which should not be overlooked is that of the active participation of public health nurses in referring family members for venereal disease examinations. The nurse's close working relationships with families and her knowledge of their health problems give her a good opportunity to assess the family health needs. Her work, particularly with pregnant women, individually or in groups, provides her with an opportunity for venereal disease education and casefinding. In our congenital syphilis study we found that 71 percent of the mothers producing syphilitic infants had no prenatal medical care. Prompt follow-up on mothers and infants with positive serologies is a highly important public health nursing activity.

Contact Interviewing

It is our belief that one of the most effective casefinding procedures is that provided through interviewing all venereal disease patients concerning their sex contacts so that these can be brought to medical supervision. Special techniques for efficient contact interviewing have been developed by the U. S. Public Health Service staff at Alto, Georgia. We have cooperated with the U. S. Public Health Service and the Georgia State Health Department in the training of approximately 112 public health workers from California. California's contact index (number of sex contacts named per diagnosed infectious case) has risen steadily since our participation in the training program. To continue improvement in casefinding through the interview method, wider use of the Alto technique is needed in California.

The day-to-day activities of a health department usually provide a number of sources for venereal dis-

ease casefinding. The full utilization of all these sources is essential to the control of venereal disease.

Research Projects

Research and experience are guideposts for new approaches to venereal disease control. Through the utilization of federal, state and local resources it has been possible to develop projects aimed at discovering more effective methods for solving our venereal disease problems.

In California a number of cooperative projects have been developed. Examples of these are:

1. The Santa Clara County project, which resulted in 80 percent of the private physicians referring their private cases to the health department for contact interviews.
2. The Treponema Pallidum Immobilization Test project currently in operation in Los Angeles. This is the first specific diagnostic test for syphilis and will make a tremendous contribution to solution of problem serology cases.
3. The Prognosis of Late Latent Syphilis, a study project under the direction of Dr. Charles Barnett at Stanford University Hospital in San Francisco. The outcome of treatment and the value of penicillin for late latent syphilis are the subjects of study in this project.
4. The permanent assignment of trained civilian interviewers to military camps. The training and civilian status of these permanent interviewers has increased tremendously the productiveness of interviews of infected military personnel in California.
5. The cooperative training project at Alto, Georgia, for venereal disease interviewers in California is effecting an increase in our contact index in this State.
6. Ambulatory rapid penicillin treatment of syphilis as well as gonorrhea patients was demonstrated effectively in rural San Joaquin County and urban Los Angeles City. These projects demonstrated that hospitalization of patients for rapid treatment is not necessary and that 95-98 percent of patients completed treatment within 10 days, returned for periodic examinations more readily than previously and continued with their daily activities without interruption.

Summary

We have discussed, chiefly, the various medical problems still existing in venereal disease control. As long as reservoirs of infection remain, we cannot accept the idea that the venereal diseases are vanishing and of no public health significance. Our progress has introduced new problems and is challenging us to search for other methods by which these diseases can be medically

and socially controlled. Our efforts are enhanced when community conscious citizens unite with their medical and allied fellow men in meeting these challenges. The average citizen can make a tremendous contribution by supporting legislation for venereal disease control, law enforcement against prostitution, and community development for the health, safety and welfare of its citizens.

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- ⁵ The Statistical Letter, Division of Venereal Disease, Office of Statistics, Public Health Service. No. 32, February 1952.
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Cooperative Rabies Control Program Planned by Border Areas

Through plans which had their origin in meetings of the United States-Mexico Border Public Health Association, a cooperative program of rabies control is being developed by neighboring areas along the border. On the United States side, San Diego and Imperial Counties are coordinating efforts with the neighboring state of Baja California, Mexico, for the control of rabies among both wild and domestic animals. The current rabies control efforts along the California-Mexico border are an extension of the Nogales rabies agreement reached at the Border Public Health Association meeting in Nogales, Mexico, in 1949, and reaffirmed at subsequent meetings in Los Angeles last year and in Monterrey, Mexico, in March of this year. This agreement provides for cooperative action by the governments of the United States and Mexico working through the Pan-American Sanitary Bureau.

In July, 1951, San Diego asked the State Department of Public Health to "initiate and coordinate" a program with the Pan-American Sanitary Bureau for the area bordering this State. PASB has recently been requested by the department to put on a demonstration project in wild life control in Baja California. This project is to be patterned after two previous wild life demonstrations held in the states of Chihuahua and Sonora, Mexico, in 1950 by PASB. As a result of those

demonstrations and continued antipredator activities by the local livestock associations, wild animals carrying rabies virus—principally coyotes and wolves—are no longer a serious problem in the control areas.

Experts in wild life control on loan to PASB from the United States Fish and Wildlife Service are to hold demonstrations in a designated control area of Baja California. The immediate objective is to train a nucleus of individuals in the methods of reducing predatory wild life that act or may act in the perpetuation of rabies, and to determine other measures necessary in that area for the effective control of rabies. Long-term results expected in the project would be continuous activity in northern Baja California to further reduce and maintain the reduction of this potentially important reservoir of rabies.

The fact that rabies is endemic in wild and domestic animals on both sides of the border and that these animals may travel back and forth across the border without hindrance emphasizes the importance of concurrent control programs on both sides of the border. San Diego County has averaged 45 reported cases of animal rabies per year for the past 25 years. These reported cases, which have probably represented only a percentage of the actual number of cases that have occurred, have included practically all animals, both domestic and wild—foxes, skunks, coyotes, wildcats and deer.

Rabies control among dogs is also under consideration in the border areas. The City of San Diego last November adopted an ordinance requiring compulsory rabies vaccination for dogs.

Rabies control along the border is just one of the many interests pursued by the Border Public Health Association. This association was established some 10 years ago in order to facilitate working relations and to provide an opportunity for better understanding between the bordering states of the United States and Mexico. Annual meetings, alternating between the two countries, have been held to consider common problems. This year in addition to the rabies problem the association considered problems relating to sanitation; to communicable disease control; to interchange of population, both employment and tourist; and to maternal and child health. There was planning for more effective use of the Pan-American Sanitary Bureau through liaison and staff necessary to provide continuity in working out mutual problems.

In line with past procedure, the State Department of Public Health this year sent representatives, including Dr. Malcolm H. Merrill, deputy director; Dr. Belle Dale Poole, Bureau of Maternal and Child Health; Mr. Edward Reinke, Bureau of Sanitary Engineering; and Mr. Walter Joslin, Bureau of Venereal Disease.

State-wide Training in C.D. Sanitation to Stem From Asilomar Meeting

Local health officers in the State have been notified by the State Health Department of plans for organized in-service training of environmental sanitation and collaborating personnel in the handling of natural and wartime disasters.

Primary objective of this project, as announced in the memorandum sent recently to the health officers, is the development of a manual which will incorporate recognized public health procedures, but modify them where necessary with the latest and best technical guidance from professional personnel in the State. The manual will be worked out cooperatively by the State Office of Civil Defense, California Conference of Local Health Officers, and State Department of Public Health, following a concentrated planning session scheduled for June 8th to 11th at Asilomar.

A "working guide" in the sanitation phases of civil defense and disaster situation is being prepared, in anticipation of the Asilomar meeting, by various specialists in the State Health Department and local departments. This guide will describe fundamental operating procedures. Each person attending the working conference at Asilomar will have been supplied with copies of this guide, which will then be discussed and modified according to group opinion. An example of the practical ideas in the guide is the Los Angeles City Health Department's plan for converting gasoline trucks into water carriers in a time of disaster.

The memorandum sent to local health departments sets forth the objectives of in-service training, followed by the steps considered necessary to the development of a manual of uniform sanitation procedures during an emergency (viz., sewage disposal procedures in a refugee center when sewers become clogged). Some of these steps, to be taken following the Asilomar planning discussions, are as follows:

1. Rewriting of each procedure in the light of suggestions made at the June conference.
2. Extension of training of state and certain local sanitation personnel, together with certain key extra-departmental persons, on a civil defense regional basis. Attending regional training sessions of this kind would be field sanitation staff of the State Department of Public Health, local health department directors of sanitation, department specialists in civil defense sanitation, local training officers, and the nondepartmental people mentioned above.
3. Further extension of training by holding conferences in each local health department jurisdiction. These would be attended by local sanitation workers, collaborating volunteers and other non-health-trained individuals, and local health educators—the latter be-

ing qualified specially to help extend training in basic sanitation procedures to the general public.

4. Incorporation of civil defense training into sanitation curricula of California universities and colleges.

IV. Review of Reported Communicable Disease Morbidity—April, 1952

Diseases With Incidence Exceeding the Five-year Median

Diseases	April 1952	April 1951	April 1950	5-Year Median
Chickenpox	9,647	5,401	4,580	6,796
Encephalitis	6	4	6	4
Food poisoning	173	37	128	38
German Measles	2,550	755	283	682
Hepatitis, infectious	45	17	34	17
Influenza	484	452	64	135
Measles	10,885	15,151	2,536	8,276
Meningitis	54	18	17	22
Pertussis	443	189	923	418
Poliomyelitis	48	51	45	34
Animal Rabies	23	4	10	20
Salmonella infections	64	22	41	17
Shigella infections	62	29	10	19
Streptococcal infections, respiratory, including Scarlet Fever	1,008	866	520	520

Diseases Below the Five-year Median

Diseases	April 1952	April 1951	April 1950	5-Year Median
Coccidioidomycosis	6	8	12	8
Diphtheria	15	11	33	33
Mumps	4,471	1,997	5,024	4,662

Positions for Public Health Nurses

Examinations by interview, to fill Los Angeles City vacancies in public health nurse positions with a new pay range of \$303 to \$375 per month effective July first, are announced by Joseph W. Hawthorne, General Manager of the Los Angeles City Civil Service Department.

The new salary rate, which is a considerable improvement over the old starting pay of \$273 per month, is expected to attract more applicants into the service of the city in this important field. California registered nurse and public health nurse certificates are required for these positions.

Further information, detailed announcements, and application forms may be obtained in Room 5, Los Angeles City Hall, or by telephoning Michigan 5211, Extension 2936.

L. A. County Health Department Moves

The Los Angeles County Health Department has moved its offices from 808 North Spring Street to 241 North Figueroa. The new location provides 60,000 square feet of floor space, as compared with only 26,000 at the old address. The department, directed by Dr. Roy O. Gilbert, has 13 district offices.

U. C. Schedules Summer Course on Health Aspects of Survival

The University of California School of Public Health and the University Extension, with the cooperation of the California State Civil Defense Organization, are offering teachers and students of health a two-unit course (X301) on "The Health Aspects of Survival" at Berkeley, June 23-July 3, 1952. This year's session has been expressly designed to provide appropriate objectives and scientific materials for instruction of the general college and high school student. It is based on the now widely recognized premise that personal and community health problems are inseparable. The course is aimed at fostering an appreciation of the role of the individual in promoting sound health practices on a community-world-wide basis. Special emphasis will be placed on the importance of integrating disaster planning with the community's health program. This undertaking has been endorsed by state departments of education, public health, and civil defense in most of the Mountain and Pacific States.

Topics for Discussion

The Need for Disaster Preparedness
Medical and Health Services in Civil Defense
Disaster Relief
Emergency Medical Procedures
Defenses Against Biological Warfare
Control of Contact and Air-borne Diseases
Problems of Nutrition and Mass Feeding
Food and Water Sanitation
Control of Rodent- and Animal-borne Diseases
Control of Arthropod-borne Diseases
International Health Problems
Industrial Hygiene
Public Health Aspects of Disseminated Radioactivity
Sociosexual Problems
Psychological Problems Relating to Maternal and Child Care
Organic Diseases of the Nervous System
Mental Hygiene
Social and Economic Factors Affecting Medical Care
Techniques of Instruction
Use of Audio-visual Aids

Field Trips and Demonstrations

U. S. Naval Hospital, Oakland—Medical care and rehabilitation of military casualties.
Western Training Center, F.C.D.A.—St. Mary's College, Moraga—Rescue and first aid procedures.
California State Health Department Laboratories, Berkeley—Laboratory aids in the control of disease.
East Bay Municipal Utilities District, Berkeley—Public water supplies and sewage disposal.
U. S. Navy Training Aids Center, Treasure Island—Use of audio-visual aids.
University of California Medical School, Hooper Research Laboratories, San Francisco—Experiments dealing with rodent- and animal-borne diseases.
University of California, Radiation Laboratories, Berkeley—Medical aspects of atomic energy.
California State Hospital, Agnew—Medical care and rehabilitation of the mentally ill.

For further information write to the Department of Conferences and Special Activities, University Extension, University of California, Berkeley 4, California.

Alameda County Positions

Vacancies exist in the Alameda County Health Department for the following positions: Assistant Health Officer, a second health educator, and public health staff nurses. Positions are permanent civil service with salaries on a five-step plan. County cars are available. Requests for information should be sent to Dr. James C. Malcolm, Health Officer, 576 Callan Avenue, San Leandro.

Dr. Otis L. Anderson Heads PHS State Service Bureau

Dr. Otis L. Anderson has been appointed Chief of the Bureau of State Services in the Public Health Service. Dr. Joseph W. Mountin, who had succeeded to the post less than a year ago, died suddenly on April 26th. Dr. Anderson, a member of PHS commissioned corps since 1930, has been Associate Chief of the Bureau of Medical Services since 1949. In his new position, he will direct the service's federal-state and interstate programs, which include grants-in-aid, tuberculosis and venereal disease control, water pollution abatement, occupational health activities and vital statistics.

New Appointments Announced by Civil Defense Chief

Major General Walter M. Robertson, State Director of Civil Defense, has announced several shifts and new appointments in regional coordinating positions in California's civil defense organization.

Colonel John E. Ardrey, U.S.A. ret., has been appointed by Governor Warren as Regional Coordinator for Civil Defense Region 6, which is made up of Merced, Mariposa, Madera, Fresno, Kings, Tulare, and Kern Counties. This position was vacated by recall to active army duty of Col. Harry Braze. Col. Ardrey himself has been serving as assistant coordinator of Region 6, and will be replaced in this position by George N. Hartwell following the latter's resignation as Deputy Mayor of Fresno.

Newly appointed as Regional Coordinator for Civil Defense Region 2 is Keith E. Ward of Chico. Mr. Ward will be responsible for civil defense planning and organization in the nine northeastern counties, operating from headquarters at Redding.

Nursing Vacancy in Marin

Marin County Health Department will have a vacant position for a staff public health nurse on September 1, 1952. The salary range is \$285 to \$360. For further information address Clarice H. Haylett, M.D., Marin County Health Officer, 704 Fourth Street, San Rafael, California.

State Laboratory Staff Devises New Testing Procedure

F. W. Hartmann, Sc.D., Chief Bacteriologist-Chemist, and Lois Yee, A.B., Assistant Public Health Chemist, Sanitation Laboratory, California State Department of Public Health, have devised an improved method for evaluating quaternary ammonium compounds. The method is an uncomplicated procedure which can be carried out readily and with reproducible results in most well-equipped public health laboratories, without recourse to bulky equipment or supplies not usually on hand or at least available from the usual commercial sources.

In 1947 the California State Department of Public Health approved 11 quaternary ammonium compounds for use in the bactericidal treatment of eating and drinking utensils. Approval of the selected quaternaries simply added to the list of disinfecting agents which could be elected and in no way interfered with the use by restaurants of heat or chlorine treatment if these proven methods were preferred by the management.

Initially, approval of the quaternaries was based on data then in the literature regarding their efficacy as bactericidal agents. At the same time it was realized that some provision should be made in the Division of Laboratories for evaluating additional compounds in the series as they were proposed for use. Accordingly, data on various testing methods which had been proposed were collected. A number of procedures were encountered in the literature, which, though excellent for their intended purposes, were not well suited to the specific needs of the testing program envisioned.

A method was desired which would permit comparisons to be made between compounds newly proposed and those which were already being given field trial. The method should embody conditions which at least approached those of actual use. Also, the aim was to evaluate bactericidal properties alone rather than the resultant of bactericidal and detergent characteristics. It was apparent from the very outset that such a method would of necessity be a compromise between the usual field and laboratory practices.

The new method developed by Dr. Hartmann and Miss Yee has been outlined clearly in step-by-step procedure and is available in mimeographed form from the Sanitation Laboratory, 1775 Shattuck Avenue, Berkeley. The exact title is "A Current Method for Evaluating Quaternary Ammonium Compounds."

Drug addiction is caused by human weakness—not by drugs—and is a symptom of a personality maladjustment rather than a disease in its own right. Emotionally normal, mature individuals practically never become addicted.—Harris Isbell, M.D., National Institute of Mental Health.

Younger Age Groups Lead State's Population Growth

New light is thrown on the extent and nature of California's population increase by a recent report, "Provisional Annual Estimates of the Population of the State of California, 1940-1953," prepared by Dr. Carl M. Frisen of the State Department of Finance.

Particularly notable are the gains made by this State in the number of residents in "pre-productive" and "most productive" age groups. These and other interesting facts appear in the following excerpts from Dr. Frisen's report prepared by the Bureau of Records and Statistics of the State Department of Public Health.

California's population increased from 6,907,387 to 10,586,223 between 1940 and 1950. The net gain was greater than the State's total number of residents in 1920. More than 2.6 million new residents migrated to the State in the 10-year period. With 1.9 million births and 900,000 deaths, the added growth of 1,000,000 from natural increase was approximately equal to the 1920 population of the San Francisco-Oakland metropolitan area.

During the first half of the decade migration accounted for over three-quarters of the population increase, but after the war the excess of births over deaths became increasingly important as a source of new population.

California's population gains during the last decade were especially high in the younger ages.

For Every 100 Persons in Each Age Group in 1940 There Were in California, in 1950:

244	under 5 years of age
163	aged 5-14 years
143	aged 15-44 years
142	aged 45-64 years
156	65 years and over

Of the total number of persons added to the State's population, 73 percent were under 45 years of age, representing additions to the preproductive and younger economically productive years of life.

The following table from Doctor Frisen's report shows the changing age composition of California and the United States from 1900-1950. The 1950 census data by age group are from preliminary reports while the totals are final counts released by the Bureau of the Census.

Percentage Distribution of Population by Age—California and the United States, 1900-1950

Year	All ages	0-14	15-44	45-64	65 and over
California					
1900	100.0	26.4	51.2	17.1	5.2
1920	100.0	23.9	49.9	20.4	5.9
1940	100.0	19.8	49.1	23.1	8.0
1950	100.0	24.6	45.8	21.4	8.2
United States					
1900	100.0	34.5	47.8	13.7	4.1
1920	100.0	31.8	47.4	16.1	4.7
1940	100.0	25.0	43.3	19.8	6.9
1950	100.0	27.2	44.5	20.2	8.2

Council Recommends Hospital Plan Changes, Approves Projects

Meeting in Los Angeles on April 24th, the State Advisory Hospital Council reviewed basic policies for the development of the state plan for hospital and health center construction, to be effective from July 1, 1952, to June 30, 1953. The council recommended that this department adopt the following policies for the state plan.

I. General Hospitals

That the delineation of hospital service areas be based on three principles:

- A. In isolated rural sections of low population it is recognized that small institutions are necessary to provide service within one-hour travel time of area residents. In such instances an area is established where population to be served exceeds 5,000; where population is less than 5,000 it is impossible or at least not feasible, economically, to support a hospital.
- B. In sections of greater population areas are created to provide facilities within 30 minutes travel time of all area residents. In such instances individual communities are grouped into a single area. The principle of service within 30 minutes applies to areas which can support 50 or more beds.
- C. In metropolitan regions with relatively high density of population and congested transportation facilities, areas are created to reflect major community groupings for hospital services, including medical and related activities. Recognizing the inter-relationships of population and its fluidity for purposes of employment, business, medical, hospital, and other activities, areas are established which combine communities within reasonable distance and travel time of the established centers within the region.

Adoption of these principles for delineation of hospital service areas will result in a change from 101 hospital service areas to 110 hospital service areas. It was the council's opinion that the concept of providing hospital facilities within 30 minutes for population groups capable of supporting 50 or more beds, gives recognition to the phenomenal population growth in the State, community development and generally accepted philosophy and concern of the citizens for provision of medical and hospital services.

II. Tuberculosis Hospitals

It was recommended that the determination of need for tuberculosis facilities be based upon average annual death rate for the period 1946-1950. In addition, the council instructed Mr. Gordon R. Cumming, Chief of the Bureau of Hospitals, to present to the Federal Hospital Council during its meeting on May 6th the council's opinion that the existing basis for determination of tuberculosis bed needs is not realistic because of the earlier stage case finding, prolonged hospitalization, and reduction in deaths from tuberculosis; and to request the Federal Hospital Council to consider a revision of the statutory requirement of 2.5 beds per average annual death.

III. Chronic Disease Hospitals

No change recommended.

IV. Health Hospitals

No change recommended.

V. Health Centers

The council approved continuation of previous policies for determination of health center needs and establishment of priority for consideration, except for adjustment in total space requirements allowable for population served by public health jurisdictions. The increased space requirements are based on experience and observation during the planning and construction of some 15 public health centers during the past four years.

The council recommended the allocation of federal and state funds for the following projects:

	Federal	State
Alameda County Public Health Center.....	\$110,000	\$110,000
Del Norte County Local Hospital District (chronic)	79,000	79,000
Roseville Municipal Hospital (general) (assistance for equipment only)	17,000	17,000

These funds became available for allocation at the April meeting because two applicants receiving approval for grant in October, 1951, were unable to demonstrate sufficient local financial resources, within four months following allocation, to proceed with their projects. The funds must be encumbered by a contract prior to June 30, 1953.

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